STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING _____ B. WING _____	C 08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK REHABILITATION CONVALESCENT CENTER	5430 WEST U.S. 40 GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00093890. Complaint IN00093890 - Unsubstantiated due to lack of evidence. This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on 7/12/11 to the Investigation of Complaint IN00091349 completed on 6/15/11. Survey dates: August 2 and 3, 2011 Facility number: 000157 Provider number: 155254 AIM number: 100274720 Survey team: Barbara Gray RN TC Leslie Parrett RN Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicaid: 5 Medicaid: 39 Other: 3 Total: 47 Sample: 3 Sugar Creek Rehabilitation Convalescent Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC in regard to the Investigation of Complaint IN00093890.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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